Alberta Doctors' Digest

Two oncologists walk into a bar ..

Lengthening wait-times in Alberta and the rest of Canada to see medical specialists and general practitioners is a huge concern. One current very worrying area in Alberta is oncology with now over-lengthy, dangerous wait-times to see a specialist and start treatment. One cause is difficulty recruiting senior staff to the provincial cancer centres due to a variety of factors.

And Canada is not the only place experiencing this distressing problem. Long waits for cancer care have become routine across the UK with nearly half of specialist cancer centres experiencing delays (according to the UK's Royal College of Radiologists). The college has warned of an "impending crisis" in the cancer workforce, with a 30 percent shortfall in radiation oncologists and 15 percent shortfall in medical oncologists.

Why is this happening? The incidence of malignant disease is increasing due in part to social factors and medical success. As we live healthier lives, live longer, and are treated successfully for disorders previously regarded as lethal – infections, heart diseases and cancers – we're more prone as we age to develop other malignant diseases and conditions like Alzheimer's dementia. My old friend Dr. John Boyd used to say: "In your seventies, you never know what's coming round the corner … but something is."

Dr. Jackson Wu

Between 1994 and 2020, the annual cancer incidence in Canada rose 88% from 120,255 to 225,800 cases. In public media and in letters to AMA members, Alberta Medical Association President Dr. Paul Parks has recently publicized the critically important issue of wait-times to consult an oncologist and to start appropriate therapy.

He’s questioned whether we’re training enough oncologists (medical, radiation, gynecological and surgical) for the future. Alberta at present needs approximately 50 oncologists to keep up with recent retirements and trainees leaving this province for more attractive jobs elsewhere.

Fundytus et al1 examined the number of medical oncologists (MOs) in Canada from 1994 to 2020.

- MOs increased from 161 in 1994 to 642 in 2020 (a 298 percent increase).
- The ratio of new cancer cases per annum to medical oncologist dropped from 749:1 in 1994 to 352:1 by 2020.
- In 1994, only 24 percent of MOs were ≥ 50 years old compared to 40 percent in 2020.
- Trends in Canadian MO trainees show an increase from 34 in 1994 to 103 in 2020.

In the early years of oncology, a fair number of patients were well dealt with by “internists with an interest” (e.g. Dr. Neil Graham in Red Deer and Dr. Adam Vyse in Okotoks). This approach continues but is becoming harder as protocol complexity increases. And although the Canadian oncology workforce has grown between 1994 and 2020, a high portion of MOs are now nearing retirement age. The increased number and complexity of systemic therapies and the older average of patients has also influenced workload.

Dr. Parks has done an excellent job bringing this issue to public and governmental attention: "We’re just not competitive in recruitment compared to Ontario, BC or other provinces; well-trained appropriate candidates are not coming to Alberta at the level we need.”

Thirteen approved oncology training programs in Canada have all four components of training available (medical, radiation, gynecological and surgical); the top five programs (EDU ranked) are University of Toronto, University of British Columbia, McGill, University of Alberta and University of Calgary. Alberta has fallen behind in the recruitment of trainees completing training partly due to lower salaries than in other provinces.

Health Minister Adriana LaGrange says Alberta has recruited 17 full-time cancer care Alberta doctors to start between 2024 and 2025, and work is underway with the AMA on a new master agreement for oncologists. However, more than half of these doctors are replacements for oncologists who are retiring or moving away. Dr. Parks wants to see pay rates increased for cancer care doctors, more oncology training spaces created in Alberta and a long-term provincial plan on workforce. These should be tackled urgently. If unsolved, they have the potential to become a major election issue.

Further increasing the pressure, cancer centres that have been opened in smaller cities (Lethbridge, Red Deer and Grande Prairie) also require appointments of cancer specialists, who are also being actively courted by centres in smaller cities opening in B.C. and other provinces where remuneration is higher.

Oncology has become a more complex field than when I started in the 1970s. Then, we were exploring the use of cytotoxic drugs in acute leukemias, lymphomas, breast and testicular carcinomas. Radiation was used in situations where surgery was not possible or advisable.

Now, the oncologist has to deal with protocols for malignancies in every body organ and tissue, together with genetic and pathological testing, a myriad of complex drugs, immunotherapeutic agents, together with advanced diagnostics and computerized communication and ordering systems. Many more patients than even 20 years ago now are deemed eligible for curative or worth-while palliative therapies – but often they're older, with co-morbidities, and on multiple drugs.

So the last thing we need is a report from me of a popular radiation oncologist's retirement party in early June – that of Dr. Jackson Wu, a skilled and kindly radiation oncologist of the Tom Baker Cancer Centre.

I talked to Jackson after the party about why he was retiring early (he's under 65.) To me, he's an example of that important combination of a clinician interested not only in cancer and radiation biology but also in the human aspects of care, particularly the importance of good patient relationships.

Jackson has spent 30 years in radiation oncology, doing his residencies at the BCCA 1994-98, then working in Toronto 1998-99 and in Hamilton Regional Cancer Centre in 2000-2002. He came to Calgary's Tom Baker Cancer Centre in 2002 and quickly became known as an excellent radiation oncologist, not only as a technical and scientific expert but also an all-round doctor who could communicate effectively with patients. He knew how to make patients feel cared for and that their plight was understood.

Jackson described three phases in his career.

- The first was applying his technical and medical knowledge to treat lesions.
- The second was a 10-year period of exploring "evidence-based oncology" – initiating, organizing and participating in international clinical trials and integrating palliative care into his technical and medical training.
- The third was precipitated by the death of his sister, who'd suffered from a metastatic cholangiocarcinoma and died in 2015 in Vancouver.

Jackson's sister had much pain but was eventually managed satisfactorily with palliative care. She'd explored the recently legalized medical assistance in dying (MAID) programs. Although not receiving MAID, she and Jackson talked a lot about it, and he saw that in the right circumstances it was the thing to do.

Jackson joined the Foothills Hospital/University of Calgary AHS Cancer Care Expert Panel for Physician-Assisted Death in 2015 and started to work part-time in that area while continuing radiation oncology, dealing mostly with prostate cancer patients. We also discussed changes in the management of oncology patients, which may have influenced his decision to retire. He emphasized it was not financial but more of a weariness with the "industrialization" of care that had been happening over his career. Complexities of care had increased, but with this, there was a prioritization of this complexity over human contact and the need for patients to feel and know they are being heard.

"A patient is more than a list of problems," he says. "Quality care can be compromised by seeing them as that. In order to help a patient make sense of their plight, it's important to have time to help them understand their disease." I asked him if Epic's Connect Care had anything to do with this. "To some degree," he said. He preferred the previous Aria and Sunrise systems.

There is no perfect software system, and some clinicians do prefer Epic's Connect Care system, where the clinical information is widely and quickly available. My daughter, a general practitioner, likes getting immediate reports and treatment plans from Connect Care – though, interestingly, general practitioners will be using a different IT system.

A phenomenon has occurred that I was unaware of. Most clinicians now "prep" their clinics before doing them. When I was seeing patients, if you had a clinic you switched on the computer and got on with it, making decisions about investigations, treatments, referrals and completing prescriptions when one saw the patient. Senior nursing staff would help with some forms and making appointments. One senior radiation oncologist told me she now spends two hours before a large clinic preparing information on likely requirements (e.g. X-ray forms, referrals, blood tests or prescriptions). This information is then widely available, so patient "flow" may be improved – but at a cost of increased time prepping.

Epic is an American system that was originally devised for in-patient hospital billings and is good for these purposes, recording every decision. I asked Dr. Mark Clemons, an old friend in Ottawa, who has used Epic for several years, for his thoughts.

"Everything comes to you. Everything," said Dr. Clemons. "Things that used to be done by appointments departments, like changing appointments, or by in-clinic nursing staff, now come to you. A simple thing like prescribing Tamoxifen takes longer on this program. Mistakes take longer to correct. Multiple flash box warnings may be a double-edged sword – the more that come up, the more likely you are to ignore them. The computer then has a record of all warnings that were ignored!"

Other specialists described to me a reduction in the all-important "face time" with patients. Some patients with more complex problems need more time than others to provide quality care, but the slot system can limit the time available for this. To compensate, shouldn't we consider (as happens in the USA) the use of scribes or administrative assistants to train on the system and take this non-medical labour from the clinicians? The employment of locums is made difficult by the complexity of the system.

It would help if there were regular clinical reviews of Epic's Connect Care from a physician's perspective. A review was done last year (AHS 2023 Arch Collaborative Survey Findings), but it focused on technical issues and used a lot of jargon (e.g. "digital health ecosystems.") It found physicians, by a long chalk, were the least satisfied with the system. Surely the system can be improved for them?

Some patients require more time that others. Reduce the prioritizing of slot time. Reduce the complexity of prescribing. Many screens to prescribe Tamoxifen could be reduced. Oncologists having to change appointments, cancel therapies and fill out forms takes away from face time with patients.

Another comment from Jackson Wu was that it's important to use skilled nursing staff optimally. He worried that moves may be being made to reduce the nurses attached to "tumour groups," established during the 1990s, where senior nurses became closely involved with patient care continuity. They know the patients and can answer most management questions within their tumour group. This has worked well, but there is now talk of a move back to "team-based care." There may be fiscal reasons I don't know about here, but nurses would be moved around tumour programs as and when their

skills were required. This may solve immediate issues, but there would be less care continuity and patient satisfaction.

So, what might help recruitment to improve this serious and worrying increase in wait-times to see an oncology specialist and start treatment?

- Adjust the oncology pay scales to match levels in BC and other provinces. Some of the differences annually involve many thousands of dollars. This should be done quickly since increasing the numbers of oncologists takes months and years of hard work.
- Increase funding to allow opening hours of radiotherapy departments and chemo/immunotherapy clinics to include Saturdays, Sundays and evening hours until wait-times return to tolerable levels. Unfortunately, we know that sustainability can be a problem here since this can only be done for short periods before significant staff burnout occurs.

- Remove non-medical tasks from the work of the oncologist. Consider the use of scribes or admin assistants where needed in using Connect Care. Many oncologists may not want or need this help, but some will welcome the help of a skilled user. It should improve the ability to hire locums from other jurisdictions.

- Preserve the big contributions of experienced nurses to the continuity of patient care rather than reverting to nursing care teams unless there is a fiscal and personnel emergency (which there might well be).

- Engage in broad discussion, on a societal level, of issues like palliative treatments of elderly patients with toxic medications. Older patients' expectations may have to change; we need to examine whether everyone needs/wants active therapy. In the 1970s, we were taught that a chest infection could be "the old man's friend."

In this era of artificial intelligence, medicine and surgery very much need the human touch.

Editor's note: The views, perspectives and opinions in this article are solely the author's and do not necessarily represent those of the AMA.

Reference:

1. Fundytus et al (Journal of Clinical Oncology Vol 40. 16_supplement) published 2022.